Arkansas State Board of Pharmacy
101 East Capitol, Suite 218
Little Rock, AR 72201
501-682-0190
http://www.state.ar.us/asbp

Training Plan
for an Intern Pharmacist

Please note: You must have a *Training Plan* on file at the Board of Pharmacy in order to receive credit for experience hours. A *Buff Card* will be sent to the pharmacy listed on this *Training Plan* to allow you to work and gain pharmacy experience hours. Do not work until the pharmacy has received the *Buff Card*.

(Please print or type)

NAME: Last First Middle	Intern License #	For office use only Date Received:_____ Processed by:_____ Intern No._____
HOME ADDRESS: Number Street		
City State Zip		
MAILING ADDRESS: If different from above, indicate your mailing address:		
Home Telephone Number ( )	Daytime Telephone Number ( )	
Academic classification (check one) P2 ___ P3 ___ P4 ___ Graduate___	Social Security Number	
Type of practice Community/Retail…..___ Hospital……..___ Research……___ Other ……..___	If you checked "other", please describe here.	
Pharmacy Name	Pharmacy Permit #	
Pharmacy Address _____ number and street _____ city, state, zip	Pharmacy Phone Number ( ) Pharmacy Fax Number ( )	
I will be employed approximately _____ hours per week.		

(Please print)
Name of Intern Pharmacist_____
First Middle Last

Intern Agreement:

Please carefully read and sign below.

I understand that, as in intern, I may not perform any duties required of a pharmacist except when I am working under the direct and personal supervision of a pharmacist preceptor. I also understand that should I perform any duties which I am not licensed to perform, or should I take charge of and operate a pharmacy in the absence of a pharmacist, I am placing my ability to become a licensed pharmacist in jeopardy.

I further understand that I must have a *Training Plan* on file at the Board of Pharmacy in order to receive credit for experience hours. A *Buff Card* will be sent to the pharmacy where I plan to gain pharmacy experience hours. I cannot work until the pharmacy has received the *Buff Card*.

I must submit a record of my intern experience on the *Affidavit of Experience*, certified by the preceptor under whose immediate supervision such experience was attained, if I expect to receive credit for such experience toward completion of my experience requirement.

I understand that this license must be renewed each year on May 1st. If the intern license is not renewed by June 1, a $20.00 penalty will be due. If the license is not renewed by July 1, a penalty of $40.00 will be due. My license will be null and void if I fail to renew it August 1.

I understand that falsification of the information on this form may constitute grounds for denial or revocation of the registration. I hereby certify under penalty of perjury under the laws of the State of Arkansas to the truth and accuracy of all statements and representations made in this application and that I personally completed the application. I understand that I must notify the Board in writing of any change of address during my internship. I have read and understand the instructions and statements on this application.

_____ _____
Signature of intern pharmacist Date signed

Preceptor Agreement:

I accept the responsibility to personally supervise _____,
(please print intern name)
an intern pharmacist, at all times when he/she is performing duties that are defined as the practice of pharmacy in this pharmacy. The intern pharmacist will work approximately _____ hours per week.

_____ _____
Preceptor's Name (please print) Alternate Preceptor's Name (please print)

License #_____ License #_____

_____ _____
Preceptor's Signature Alternate Preceptor's Signature

_____ _____
Date Date